CLIENT INFORMATION

Last Name: ________________________First Name:_______________________ MI:____

Address: ____

City/State/Zip: ____

Phone: Home__________________ Work____________________Cell_________________________

Birth date: ____________________ Sex: M F T

Email address: ____

Marital status: Married Partnered (Not married) Single Divorced Widowed Separated

Employer/Address: ____

Who referred you? ____

CLIENT'S EMERGENCY CONTACT/PARTNER/GUARDIAN

Last Name: ________________________First Name: _______________________MI:____

Address: ____

City/State/Zip: ____

Phone: Home_________________ Work___________________ Cell_________________

Relationship to client: ____

Birth date: _______________________________

Email address: ____

Spouse's Employer and Address:

____

In the case of an emergency, I consent for my therapist to contact the person listed above.

____

Signature Date

HEAD / HEART

UNIQUE THERAPY FOR UNIQUE PEOPLE

CLIENT HISTORY

Please briefly complete the form below.

Occupation:	Cultural background/ethnicity:
___________________________________	___________________________________
Educational background:	Spiritual/religious beliefs:
___________________________________	___________________________________
Medical history/concerns:	Legal history/concerns:
___________________________________	___________________________________

Current medications/herbs you are taking and dosages:

Medicine/herb	Dosage

Who is in your family?

Name	Relationship

Describe your living situation and who lives in your home:

____

____

____

Please describe your relationship with food and any concerns you may have about this:

____

____

Describe your drug and/or alcohol use:

Type	Amount	Frequency	Past/Present?

Have you ever felt the need to cut down on your substance use? ☐ Yes ☐ No

Have you ever felt you had a problem with substance use? ☐ Yes ☐ No

Have friends or family ever complained about your substance use? ☐ Yes ☐ No

If you answered yes above, please describe: ____

____

Have you ever been in recovery from substance use? ☐ Yes ☐ No

If yes, please describe your experiences (12-step, SMART Recovery, sponsorship, etc.):

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____

What is your family history of drug or alcohol problems?

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Describe any family history of mental health issues:

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____

Describe any current or past episodes of self-injurious behavior or thoughts (substance abuse, thoughts of harming oneself, etc.) ____

____

HEAD / HEART
UNIQUE THERAPY FOR UNIQUE PEOPLE

Have you ever been psychiatrically hospitalized? If so, for what and when did this happen?

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____

Check any traumatic or difficult events you have experienced:

- ☐ Loss of loved one
- ☐ Accident: car, bike, natural disaster
- ☐ Violence
- ☐ Abuse: emotional, sexual, physical
- ☐ Witnessing something disturbing
- ☐ Medical procedure

Please describe how these events still impact you today:

____

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What is your relationship status and history?

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How would you describe your sexuality? Is there anything about your sexuality that is concerning at this time?

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Describe your support system (family, friends, community):

____

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At this time, how would you describe your general state of self-care, well-being and energy?

____

____

What motivates or energizes you?

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HEAD/HEART
UNIQUE THERAPY FOR UNIQUE PEOPLE

If you could improve one thing in your life, what would it be?

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What is going well in your life?

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What would people say your strengths and areas for growth might be?

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What brings you to Head/Heart Therapy at this time?

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What are the main goals or issues you'd like to address in therapy?

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Describe past experiences with therapy and/or your thoughts/concerns about therapy:

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What else is important for your therapist to know before working with you?

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Please check if you are experiencing any of the following symptoms:

Physical State
- ☐ Low energy or Fatigue
- ☐ Headaches
- ☐ Constipation
- ☐ Nausea
- ☐ Dizziness
- ☐ Anxiety
- ☐ Allergies or frequent colds
- ☐ Indigestion

Mental/Emotional State
- ☐ Moodiness
- ☐ Temper or Anger Outbursts
- ☐ Crying Spells
- ☐ Lack of interest or depression
- ☐ Worrying
- ☐ Vague fears or anxiety
- ☐ Fidgety or restless
- ☐ Negative or critical feelings about yourself
- ☐ Compulsive or intrusive, unwanted thoughts

Sleep
- ☐ Restless sleep
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Hypersomnia (too much sleep)

Stress levels: Indicate stress or concern in any of these areas
- ☐ Family
- ☐ Friendships
- ☐ Significant other/partner/spouse
- ☐ Work
- ☐ Sex life
- ☐ School
- ☐ General well-being/health
- ☐ Finances
- ☐ Coping with daily problems
- ☐ Emotional well-being
- ☐ Spiritual well-being
- ☐ Purpose in life
- ☐ Food
- ☐ Exercise or fitness

What other types of healing modalities or therapies are you involved with?

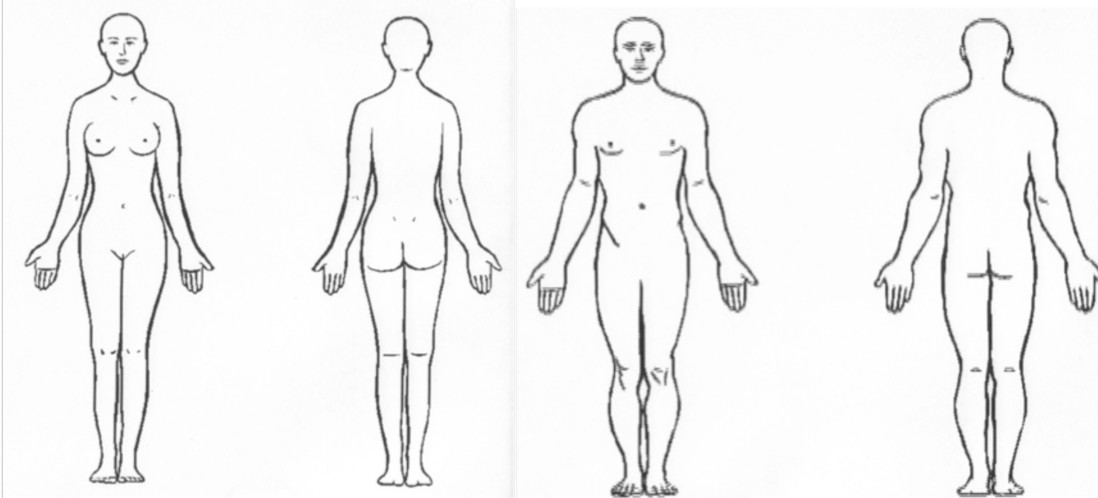
- ☐ Chiropractic
- ☐ Energy work (Reiki, healing touch or other?)
- ☐ Life coaching
- ☐ Massage
- ☐ Yoga
- ☐ Meditation
- ☐ Acupuncture
- ☐ Ayurveda
- ☐ Health coaching
- ☐ Tai chi or Qigong

Please check if you have an interest in discussing these types of healing modalities or getting referrals for these services:

- ☐ Chiropractic
- ☐ Energy work (Reiki, healing touch or other)
- ☐ Life coaching
- ☐ Massage
- ☐ Yoga
- ☐ Meditation
- ☐ Acupuncture
- ☐ Ayurveda
- ☐ Health coaching
- ☐ Tai chi or Qigong

HEAD/HEART
UNIQUE THERAPY FOR UNIQUE PEOPLE

Please indicate areas where you might be experiencing any pain, tension, concerns or stress:



____

Office use only:

SRA: Current (active/passive) – past (active/passive) – active attempts

____

HRA: Current (active/passive) – past (active/passive) – active attempts

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Notes:____

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Diagnoses: ____

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Therapist signature Date